Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Planned Home Births Pilot Project

Billing Instructions
[WAC 388-533-500]

July 2003

About this publication

This publication supersedes all previous Planned Home Births Billing Instructions and supercedes the Planned Home Births portion of Numbered Memorandum 01-39 MAA.

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of the inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider; submit a provider change of address or ownership; or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

How do I become a planned home birth provider?

Send qualification requirements to be a home birth provider to:

Planned Home Birth Program Manager
Division of Medical Management
Program Mgmt & Authorization Section
PO Box 45506
Olympia, WA 98504-5506

(The qualifications requirements are listed in the Qualification Requirements section.)

Where do I send my claim?

Planned Home Birth Program Manager
Division of Medical Management
Program Mgmt & Authorization Section
PO Box 45506
Olympia, WA 98504-5506

Where do I send my Planned Home Birth Outcome Report?

OMPRO
ATTN: Home Birth Program Manager
2020 SW 4th Avenue, Ste. 520
Portland, OR 97201-4960

Where do I call if I have questions regarding…

Planned home births policies and billing questions?
Planned Home Birth Program Manager
(360) 725-1575/atterbj@dshs.wa.gov

Newborn Screenings?
Michael Glass
Department of Health
(206) 361-2890
Email: mike.glass@doh.wa.gov

Medical Information?
University of Washington
Med Con Line
(800) 326-5300

Maternity Case Management Services/ Maternity Support Services?
MAA Family Services Section
(360) 725-1655

Private insurance or third party liability, other than Healthy Options?
Coordination of Benefits Section
(800) 562-6136

Healthy Options- Managed Care exemption or disenrollment?
(800) 794-4360

Change in Healthy Options plan?
(800) 562-3022

How do I request billing instructions?
Go to MAA's website:
http://maa.dshs.wa.gov/RBRVS/rbrvs.htm

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Definitions

This section defines terms and acronyms used in these billing instructions.

Authorization Number – A number assigned by MAA that identifies a specific request for approval for services or equipment. [WAC 388-500-0005]

Authorization Requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions. See WAC 388-501-0165 for the authorization process. [WAC 388-500-0005]

Bundled Services –Services that are incidental to a major procedure and are not separately reimbursable.
[WAC 388-500-0005]
Refer to WAC 388-533-0400(1)(b).

Chart - A compilation of medical records on an individual patient.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Community Services Office(s) (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Consultation – The process whereby the home birth provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician (MD/DO) on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone.

A consulting relationship may result in:

- Telephone, written or electronic mail recommendations by the consulting physician;
- Co-management of the patient by both the home birth provider and the consulting physician;
- Referral of the patient to the consulting physician for examination and/or treatment; or
- Transfer of patient's care from the home birth provider to the consulting physician.

Core Provider Agreement – Is the basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Current Procedural Terminology (CPT™) – A compilation of descriptions of medical procedures, available from the American Medical Association of Chicago, Illinois. *CPT codes and descriptions are copyright 2002 American Medical Association. CPT is a trademark of the American Medical Association.*

Department – The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information regarding the claim associated with that report.
[WAC 388-500-0005]

Global Fee – The fee MAA pays for total obstetrical care. Total obstetrical care includes all antepartum care, delivery services, and postpartum care. [WAC 388-533-0400(1)(d)].

High-Risk Pregnancy – Any pregnancy that poses a significant risk of a poor birth outcome. [WAC 388-533-0400(1)(e)].

Home Birth Kit – Disposable supplies that are used in a planned home birth. *(See list of supplies required on page D.6.)*

Home Birth Provider -

- A midwife currently licensed in the State of Washington under chapter 18.50 RCW; or
- Nurse-midwife currently licensed in the State of Washington under chapter 18.79; or
- Physician licensed in the State of Washington under chapter 18.57 or 18.71,

who has qualified to become a home birth provider who will deliver babies in a home setting, and has signed a core provider agreement with the Medical Assistance Administration.

Internal Control Number (ICN) - A 17-digit number that appears on your Remittance and Status Report by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Managed Care - A prepaid comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. (See WAC 388-538-0500) [WAC 388-500-0005]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities. [WAC 388-500-0005]

Medical Identification (ID) Card – The document MAA uses to identify a client's eligibility for a medical program. These were formerly known as medical assistance identification (MAID) Cards. [WAC 388-500-0005]

Medically Necessary - A term for describing a requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- **"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- **"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

[WAC 388-500-0005]

Midwife – An individual possessing a valid, current license to practice midwifery in the State of Washington as provided in chapter 18.50 RCW, chapter 246-834 WAC, or an individual recognized by the Washington Nursing Care Quality Assurance Commission as a certified nurse midwife as provided in chapter 18.79 RCW, chapter 246-839 WAC. [WAC 246-329-010]

Patient Identification Code (PIC) - An alphanumeric code assigned to MAA client consisting of his or her:

a) First and middle initials (*or* a dash (-) if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name; and
d) Alpha or numeric character (tiebreaker).

Planned Home Birth – A natural birth that takes place in a client's home and is assisted by a qualified licensed midwife, certified nurse midwife who is licensed as an ARNP, or a physician.

Professional fee – The portion of MAA's reimbursement that covers the services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. [WAC 388-533-0400(1)(f)]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provider services to eligible clients. [WAC 388-500-0005]

Record - Dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service.

Referral – The process by which the home birth provider directs the client to a physician (*MD/DO*) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. [WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State law.
[WAC 388-500-0005]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP). [WAC 388-500-0005].

Transfer of Care – The process by which the home birth provider directs the client to a physician for complete management of the client's care.

Usual & Customary Charge – The fee that the provider typically charges the general public for the product or service. [WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Pilot Project

What is the goal of the pilot project?

The goal of the Planned Home Births Pilot Project is to serve pregnant clients who want to give birth in a home-setting and who are at **low risk** for adverse birth outcomes.

Qualified planned home birth providers must participate in an ongoing evaluation of the process and the outcomes of the program.

How long is the pilot project? **[Refer to WAC 388-533-0500(7)]**

MAA's planned home birth pilot project will run for five years beginning January 2001. MAA may terminate the project at an earlier date with written notice to participating providers if data reports indicate poor outcomes.

A provider may terminate participation in the pilot project at any time with written notice to MAA. The provider must make a good faith effort to transfer ongoing cases to other participating providers.

MAA may terminate a provider's participation immediately if:

- The provider fails to comply with project requirements;
- The provider's enrollment as an MAA provider is suspended or terminated;
- The MAA Medical Director determines the quality of care provided endangers the health and safety of one or more clients; or
- The Department of Health, Quality Assurance Commission suspends or terminates the provider's license to practice.

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Client Eligibility

Who is eligible for planned home births?

[Refer to WAC 388-533-0500(5)]

MAA covers planned home births when the client:

- Has an MAA-approved medical provider who has accepted responsibility for the home birth;
- Is expected to deliver the child vaginally and without complication (i.e., with a low-risk of adverse birth outcome);
- Is evaluated using MAA's Risk Screening Guidelines (see Section E) and is deemed appropriate for a home birth; and
- Presents a current DSHS Medical Identification Card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
LCP-MNP	Limited Casualty Program – Medically Needy Program

☞ Note: If the client is pregnant but her DSHS Medical ID card does not list one of the above medical program identifiers, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full scope maternity care.

MAA Managed Care Clients

- Clients enrolled under an MAA managed care plan will have a managed care indicator in the HMO column on their DSHS Medical ID card. The client's managed care plan 1-800 telephone number is located on the Medical ID card.

- Managed care enrollees must have all services arranged and provided by their primary care providers (PCP), except in the area of women's health care services. For certain services, such as maternity and gynecological care, women may go directly to a specialist in women's health without a referral from her PCP. The provider must be within her managed care plan's provider network.

- Please contact the managed care plan and the PCP for additional information on providers, including participating hospitals and birthing facilities.

- If the client's managed care plan does not contract with a midwife or pay for home births, or the provider is not in any managed care plan, please direct the client to call 1-800-794-4360.

Note: Primary Care Case Management (PCCM) clients will have the **PCCM** identifier in the HMO column on their DSHS Medical ID cards. **Please make sure these clients have been referred by their PCCM prior to receiving services**. The Woman's Direct Access health care law does not apply to PCCM clients. The referral number is required on the HCFA-1500 claim form. (See page G.7, How do I bill for services provided to PCCM clients?)

To prevent billing denials, ALWAYS check the client's DSHS Medical ID card prior to scheduling services and at the time of the service. This is to make sure proper authorization or referral is obtained from the primary care provider and/or plan.

First Steps Program Services

- First Steps services are supplemental maternity services that include Maternity Support Services (MSS) and Maternity Case Management (MCM).

- MSS is available to all women receiving Medical Assistance coverage for their pregnancies. Contracted providers, available in every community statewide, provide assessment, education, and intervention by Community Health nurses, nutritionists, and psychosocial workers. The services are provided through two months postpartum.

- MCM is available for pregnant clients with certain high-risk conditions. MCM is offered statewide by contracted providers. This service is provided up to the child's first birthday.

- For more information about First Steps services and/or a list of contracted providers, please contact the First Steps Clearinghouse at (360) 725-1666.

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Qualification Requirements to Participate

You may request approval to participate as a provider in the project by submitting a letter of request and the following information to MAA. Documentation must be current, accurate, and updated immediately if changes occur in provider status. You must renew your participation status every two years by sending MAA documentation that verifies you still meet minimum qualifications.

Note: *You must be a current MAA provider before you can apply to be in the project. To become a provider, call the telephone number listed in the Important Contacts section. After you have signed the core provider agreement, you may apply to be in the planned home birth pilot project.*

1. **List your current MAA provider number.**

2. **Copy of your current license**. MAA requires a current license (in good standing) to practice in the state of Washington as a:

a) Midwife under chapter 18.50 RCW; or
b) Nurse-midwife under chapter 18.79 RCW; or
c) Physician under chapter 18.57 or 18.71 RCW.

3. **Demonstration of attendance at births in the home setting**.
Submit a diploma of graduation from an accredited midwifery, nurse midwifery, or medical school; or a copy of current national Certified Professional Midwife (CPM) certification; and additional documentation (i.e. medical records which indicate the degree of involvement of the care provider), if necessary, to show a minimum attendance of:

- Five births in a home setting as an observer; and
- Ten births in a home setting as the primary attendant or primary under the supervision of a practitioner who meets or exceeds the requirements in this subsection. Three or more of these births must have been with a client for whom the applicant provided care during at least four prenatal visits, all stages (1-4) of labor and birth, performed a newborn exam, and one postpartum home visit within seventy-two hours after birth.

4. **Copy of current CPR certification for:**

a) Adult CPR (example: BLS card from the American Heart Association); and
b) Neonatal resuscitation that includes the use of positive pressure ventilation and chest compressions (example: Neonatal Resuscitation Program card).

5. **Documentation of provider liability insurance coverage** of $1,000,000/$3,000,000.

6. **Documentation of liability insurance claims history.** Include a signed statement that MAA has permission to verify your claims history with your liability insurance provider.

7. **Information about current participation in a formal quality improvement or professional liability review process.**

8. **Documentation of a current plan for consultation (with a medical doctor, MD, or DO), emergency transfer and transport.**

   The plan must:

   A. For the mother, specify a physician(s) who has complete obstetrical privileges, including cesarean sections, and who has admitting privileges to the closest appropriate hospital;
   B. For the newborn, specify a physician(s) who has an active pediatric practice and admitting privileges to the closest appropriate hospital;
   C. Identify the hospital(s) to which the mother/newborn will be transported in the event of a maternal/neonatal emergency; and
   D. Identify emergency transport providers that will be used to transport the mother and/or newborn to the hospital, including private ambulance, municipal aid car, and helicopter service. A copy of the form that may be used is on the next page.

9. **Documentation of arrangements for 24 hours a day,** seven days a week coverage by a MAA approved planned home birth provider.

10. **Documentation of contact with local area Emergency Medical Services (EMS)** to determine level of response capability in area, and to facilitate communication.

11. **Copy of your consent form** (that will be signed by each client to indicate agreement to participate in a planned home birth).

12. **Agreement to participate in a quality and outcomes monitoring process by completing the Home Birth Outcome Report and sending it to the designated quality assurance/quality improvement (QA/QI) organization.**

13. **Signed statement of intent to comply with the project requirements.**

Send to: Planned Home Birth Program Manager
Division of Medical Management
Program Management & Authorization Section
PO Box 45506
Olympia, WA 98504-5506
Fax (360) 586-1471

Current Plan for Consultation, Emergency Transfer, and Transport for Planned Home Births

Date: _____ **Midwife or Physician Name:** _____

1. The licensed physician who 1) is engaged in active clinical obstetrical practice including cesarean sections; 2) has admitting privileges to the closest appropriate hospital; and 3) with whom I will consult when there are significant deviations from normal in the mother, is:

   Name: _____

   Address: _____ **Telephone:** _____

   If more than one consultant, please list on back of form.

2. The licensed physician who 1) is engaged in active clinical pediatric practice; 2) has admitting privileges to the closest appropriate hospital; and 3) with whom I will consult when there are significant deviations from normal in the neonate, is:

   Name: _____

   Address: _____ **Telephone** _____

   If more than one consultant, please list on back of form.

3. In an emergency transport to the hospital, the following are available:

Private Ambulance Co. _____ **Address:** _____
Municipal Aid Car _____ **Address:** _____
Helicopter Service _____ **Address:** _____

4. In the event of a maternal/neonatal emergency in a home setting, I will transport to the following hospital(s):

   Name: _____ **Location:** _____

   Name: _____ **Location:** _____

Mail information requested above to:
Planned Home Birth Program Manager, DMM/MPMU, PO Box 45506, Olympia, WA 98504-5506

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Provider Responsibility

What is my responsibility as a planned home birth services provider? [Refer to WAC 388-533-0500(5)]

The participating provider must do all of the following:

- Verify that the client's Medical Identification Card lists the appropriate identifier (see Client Eligibility section).
- Follow MAA's Risk Screening Guidelines and consult with and/or refer the client or infant to a physician or hospital when medically necessary.
- Plan for a home birth only if the client is expected to deliver vaginally and without complications.
- Prior to planning a home birth, obtain a signed consent form (see Informed Consent under documentation required) from the client agreeing to participate in a planned home birth. Keep the signed form in the client's file.
- Provide medically necessary equipment, supplies, and medications for each client (see list on page D.6).
- Make appropriate referral of the newborn for screening and medically necessary follow-up care.
- Inform parents of the benefits of a newborn blood screening test, and offer to send the newborn's blood sample to the Department of Health (DOH) for testing (the parents may refuse this service). You must pay DOH for the cost of the tests and then bill MAA for reimbursement.
- Refer client or newborn to a physician or hospital when medically appropriate.
- Submit to the MAA-designated Quality Assurance/Quality Improvement (QA/QI) organization a completed Planned Home Birth Outcome Report for each client for program evaluation. MAA requires a completed report before payment is made, even if the client is transferred to another provider or delivery setting and the provider is billing only for prenatal care.
- Notify MAA immediately of changes in licensure and/or provider status.
- Renew participation status every two years by submitting documentation to verify continued compliance with the minimum requirements for participation.
- Comply with the requirements in Chapter 388-533 WAC and these billing instructions.

What equipment, supplies, and medications are required?

Equipment:

Oxygen tank with tubing and flow meter
Neonatal resuscitation mask and bag
Adult mask and oral airway
Fetoscope and/or Doppler device (with extra batteries if only Doppler)
Stethoscope and sphygmomanometer
Thermometer
Portable light source
Sterile birth instruments
Sterile instruments for episiotomy and repair
Tape measure
Portable oral suction device for infant

Medications:

Pitocin, 10 U/ml
Methergine, 0.2 mg/ml
Epinephrine, 1:1000
MgSO4, 50% solution, minimum 2-each of 5 gms in 10 cc vials
Local anesthetic for perineal repair
Vitamin K, neonatal dosage (1 mg/0.5 ml)
Neonatal ophthalmic ointment (or other approved eye prophylaxis)
IV fluids, one or more liters of LR

Supplies:

IV set-up supplies
Venipuncture supplies
Urinalysis supplies - clean catch cups and dipsticks
Injection supplies suitable for maternal needs
Injection supplies suitable for neonatal needs
Clean gloves
Sterile gloves: pairs and/or singles in appropriate size
Sterile urinary catheters
Sterile infant bulb syringe
Time piece with second hand
Sterile cord clamps, binding equipment or umbilical tape
Antimicrobial solution(s) for cleaning exam room and client bathroom
Antimicrobial solution(s)/brush for hand-cleaning
Sterile amniohooks or similar devices
Cord blood collection supplies
Appropriate device for measuring newborn's blood sugar values
Suture supplies
Sharps disposal container, and means of storage and disposal of sharps
Means of disposal of placenta

Prenatal Management/ Risk Screening Guidelines

Prenatal Management

[WAC 388-533-0600(1)(d)]

- **Providers must screen their clients for high-risk factors.**

- The provider must consult with consulting physicians when appropriate. Follow MAA's Risk Screening Guidelines and Indications for Consultation and Referral.

- **To be reimbursed for CPT codes 99211 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management),** the client's record must contain the required documentation as listed below.

  The diagnoses listed below are suitable for management by the midwife but do require more visits to monitor the client. Documentation of more visits is required in the client's chart.

Diagnosis Code	Condition
640.03	Threatened abortion *(first trimester).* *(May be managed by the midwife without consultation with a physician.)*
643.03	Mild hyperemesis gravidarum (*May be managed by the midwife and will require more visits to monitor the client.)*
648.83	Abnormal glucose tolerance in a gestational diabetic *(If the condition is responsive to treatment (i.e., controlled by diet alone.)*

The diagnoses listed below are suitable for prenatal co-management by a home birth provider and a consulting physician. If a physician is the home birth provider, that physician should consult with another physician as needed. These diagnoses require more frequent monitoring and MAA allows additional payment(s) to the provider. (See page G.6 for further information.) **The client's record must contain either documented consultation or actual evaluation by a consulting physician for the following diagnosis codes:**

Diagnosis Code	Condition
642.03	Benign essential hypertension complicating pregnancy, childbirth, and the puerperium (controlled without medication)
642.33	Transient hypertension of pregnancy
643.03	Threatened premature labor (after consultation and/or referral to a physician, and the midwife and physician have determined the client is stable and appropriate for close monitoring by the midwife)
648.23	Anemia (Hct<30 or Hgb<10) – Unresponsive to treatment

Other diagnosis codes will be evaluated for possible reimbursement when submitted to MAA's Home Birth Program Manager. Include a letter of explanation and office visit notes to document extra time and visits. See Important Contacts for address.

Risk Screening Guidelines for Planned Home Births

[WAC 388-533-0500(6)]

MAA does not cover a home birth for women identified with any of the following high-risk conditions:

- ✓ Previous cesarean section;
- ✓ Current alcohol and/or drug addiction or abuse;
- ✓ Significant hematological disorders/coagulopathies;
- ✓ History of deep venous thrombosis or pulmonary embolism;
- ✓ Cardiovascular disease causing functional impairment;
- ✓ Chronic hypertension;
- ✓ Significant endocrine disorders including pre-existing diabetes (type I or type II);
- ✓ Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;
- ✓ Isoimmunization, including evidence of Rh sensitization/platelet sensitization;
- ✓ Neurologic disorders or active seizure disorders;
- ✓ Pulmonary disease or active tuberculosis or severe asthma uncontrolled by medication;
- ✓ Renal disease;
- ✓ Collagen-vascular diseases;
- ✓ Current severe psychiatric illness;
- ✓ Cancer affecting site of delivery;
- ✓ Known multiple gestation;
- ✓ Known breech presentation in labor with delivery not imminent; or
- ✓ Other significant deviations from normal as assessed by the home birth provider.

Smoking Cessation Counseling for Pregnant Women

[WAC 388-533-0400(21)]

The Medical Assistance Administration (MAA) reimburses eligible providers for including smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent women who are enrolled in a managed care organization must have services arranged and referred by their primary care providers (PCP). Clients covered under a managed care organization will have a plan indicator in the HMO column on their Medical Identification card. **Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care organizations' reimbursement rate.**

Who is eligible to be reimbursed for smoking cessation counseling?

MAA reimburses the following providers who include smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within 2 months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is smoking cessation counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see page E.5); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

☞ **Note:** See "Smoking Cessation Intervention for Pregnant Clients," page E.6. Please use this form, or provide the equivalent information, to document the smoking cessation counseling provided to the MAA client.

What is covered?

- MAA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on Attachment I.

- MAA covers two levels of counseling. Counseling levels are:

  ✓ Basic counseling (approximately 15 minutes) which includes Steps 1-3 above; and
  ✓ Intensive counseling (approximately 30 minutes) which includes Steps 1-5 above.

- Use the most appropriate procedure code from the following chart when billing for smoking cessation.

CPT® Code	Description	Restricted to Diagnoses:	
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)	
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)	

- A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

  MAA covers Zyban® only

  - ✓ The product must be prescribed by a physician, ARNP, or physician assistant;
  - ✓ The client for whom the product is prescribed must be 18 years of age or older;
  - ✓ The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and
  - ✓ The prescribing provider must include both of the following on the client's prescription:

    - ➢ The client's estimated or actual delivery date; and
    - ➢ Indicate that the client is participating in smoking cessation counseling.

  To obtain prior authorization for Zyban®, pharmacy providers must call:

  Pharmacy Prior Authorization Section
  1-800-848-2842

Smoking Cessation Intervention for Pregnant Clients

Step 1: ASK–1 minute

- Ask the client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime. ☐

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now. ☐

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now. ☐

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant. ☐

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant. ☐

If the client stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If client is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assess, Assist, and Arrange.

Step 2: ADVISE–1 minute

- Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. ☐

Step 3: ASSESS-1 minute

- Assess the willingness of the client to attempt to quit within 30 days. ☐

If the client is ready to quit, proceed to Assist.
If the client is not ready, provide information to motivate the client to quit and proceed to Arrange.

Step 4: ASSIST-3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation (eg, identify “trigger” solutions). ☐
- Provide social support as part of the treatment (e.g., “we can help you quit”). ☐
- Arrange social support in the smoker’s environment (e.g., identify “quit buddy” and smoke-free space). ☐
- Provide pregnancy-specific, self-help smoking cessation materials. ☐

Step 5: ARRANGE-1 minute +

- Assess smoking status at subsequent prenatal visits and, if client continues to smoke, encourage cessation. ☐

Data from Melvin C. Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control 2000; 9:1-5

Prenatal Management/ Consultation & Referral

These definitions apply to the following tables labeled "Indications for Consultation & Referral":

Consultation - The process whereby the provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician on clinical issues that are patient specific. These discussions may occur in person, by electronic communication, or by telephone. A consulting relationship may result in:

- Telephone, written, or electronic mail recommendations by the MD/DO;
- Co-management of the patient by both the midwife and the MD/DO;
- Referral of the patient to the MD/DO for examination and/or treatment;
- Transfer of care of the patient from the midwife to the MD/DO.

Referral - The process by which the home birth provider directs the client to a physician (MD/DO) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Transfer of Care – The process by which the home birth provider directs the client to a physician for complete management of the client's care.

The client must meet MAA's risk screening criteria in order to be covered for a home birth.

Indications for Consultation and Referral

MAA expects the provider to screen out high-risk pregnancy following MAA risk screening guidelines. The following conditions may require either a consultation or referral. MAA expects the provider to use his or her professional judgement in assessing and determining appropriate consultation and need for referral in case of adverse situation. If a physician is the home birth provider, he or she should consult with another physician as needed. Referrals to ARNPs are appropriate for treatment of simple infections.

ANTEPARTUM **(Refers to the mother's care prior to the onset of labor)**	
Conditions Requiring Consultation *MAA requires physician (MD/DO) consultation and the client MAY require referral to a physician when the following conditions arise during the current pregnancy.*	**Conditions Requiring Referral** *MAA requires physician (MD/DO) consultation and referral when the following conditions arise during current pregnancy.*
• Breech at 37 weeks; • Polyhydramnios/Oligohydramnios; • Significant vaginal bleeding; • Persistent nausea and vomiting causing a weight loss of >15 lbs.; • Post-dates pregnancy (>42 completed weeks); • Fetal demise after 12 completed weeks gestation; • Significant size/dates discrepancies; • Abnormal fetal NST(non stress test); • Abnormal ultrasound findings; • Acute pyelonephritis; • Infections, whose treatment is beyond the scope of the home birth provider; • Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality; • No prenatal care prior to the third trimester; or • Other significant deviations from normal, as assessed by the home birth provider.	• Evidence of pregnancy induced hypertension (BP > 140/90 for more than 6 hours with client at rest); • Hydatidiform mole (molar pregnancy); • Gestational diabetes not controlled by diet; • Severe anemia unresponsive to treatment (Hgb<10, Hct<28); • Known fetal anomalies or conditions affected by site of birth; • Noncompliance with the plan of care (e.g., frequent missed prenatal visits); • Documented placental abnormalities, significant abruption past the 1st trimester, or any evidence of previa in the 3rd trimester; • Rupture of membranes before the completion of 37 weeks gestation; • Positive HIV antibody test; • Documented IUGR (intrauterine growth retardation) • Primary genital herpes past the 1st trimester; or • Development of any of the high-risk conditions that are listed on page E.2.

INTRAPARTUM **(Refers to the mother's care in the home any time after the onset of labor, up to and including the delivery of the placenta)**	
Conditions Requiring Consultation *MAA requires physician consultation and the client MAY require referral to a physician and/or hospital when the following maternal conditions arise intrapartum.*	**Conditions Requiring Referral** *MAA requires physician consultation and referral to a physician and/or hospital when the following conditions arise intrapartum.* ***NOTE:*** *In some intrapartum situations, due to time urgency, it may not be prudent to pause medical treatment long enough to seek physician consultation or initiate transport.*
• Prolonged rupture of membranes (>24 hours and not in active labor); or • Other significant deviations from normal as assessed by the home birth provider.	• Labor before the completion of 37 weeks gestation, with known dates; • Abnormal presentation or lie at time of delivery, including breech; • Maternal desire for pain medication, consultation or referral; • *Persistent non-reassuring fetal heart rate; • Active genital herpes at the onset of labor; • Thick meconium stained fluid with delivery not imminent; • *Prolapse of the umbilical cord; • Sustained maternal fever; • *Maternal seizure; • Abnormal bleeding (*hemorrhage requires emergent transfer); • Hypertension with or without additional signs or symptoms of pre-eclampsia; • Prolonged failure to progress in active labor; or • *Sustained maternal vital sign instability and/or shock.

*** These conditions require emergency transport.**

POSTPARTUM **(Refers to the mother's care in the home in the first 24 hours following the delivery of the placenta)**	
Conditions Requiring Consultation *MAA requires physician consultation and the client MAY require referral to a physician when the following maternal conditions arise postpartum.*	**Conditions Requiring Referral** *MAA requires physician consultation and referral when the following conditions arise postpartum.*
• Development of any of the applicable conditions listed for Antepartum and/or Intrapartum; • Significant maternal confusion or disorientation; or • Other significant deviations from normal as assessed by the home birth provider.	• *Anaphylaxis or shock; • Undelivered adhered or retained placenta with or without bleeding; • *Significant hemorrhage not responsive to treatment; • *Maternal seizure; • Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree); • *Sustained maternal vital sign instability and/or shock; • Development of maternal fever, signs/symptoms of infection or sepsis; • *Acute respiratory distress; or • *Uterine prolapse or inversion.

*** These conditions require emergency transport.**

NEWBORN **(Refers to the infant's care in the home during the first 24 hours following birth)**	
Conditions Requiring Consultation *MAA requires a pediatric physician be consulted. The client MAY require a referral to an appropriate pediatric physician when the following conditions arise in a neonate.*	**Conditions Requiring Referral** *MAA requires that a pediatric physician be consulted and a referral made when the following conditions arise in a neonate.*
• Apgar score ≤ 6 at five minutes of age; • Birth weight <2500 grams; • Abnormal jaundice; or • Other significant deviations from normal as assessed by the home birth provider.	• Birth weight <2000 grams; • *Persistent respiratory distress; • *Persistent cardiac abnormalities or irregularities; • *Persistent central cyanosis or pallor; • Prolonged temperature instability when intervention has failed; • *Prolonged glycemic instability; • *Neonatal seizure; • Clinical evidence of prematurity (gestational age <35 weeks); • Loss of >10% of birth weight /failure to thrive; • Birth injury requiring medical attention; • Major apparent congenital anomalies; or • Jaundice prior to 24 hours.

*** These conditions require emergency transport.**

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Instructions for Completing Planned Home Birth Outcome Report(s)

Objective:

To provide data including prenatal history, transfers, and perinatal complications for monitoring quality and outcomes of planned home births to Medicaid-covered women in Washington State.

General Instructions:

Home birth providers must complete MAA's 1-page (see page E.19) or 2-paged (see page E.21) Home Birth Outcome Report. The 1-page report must be completed if you are billing for prenatal care only. For example: The client moves, changes providers, or enrolls in a MAA managed care plan. The 2-paged report must be completed for all other billings.

1. Complete all sections of the appropriate report.

2. Attach a separate page with comments as needed.

3. Submit the completed HCFA-1500 claim form to MAA's Home Birth Program Manager (see Important Contacts section for addresses) for Medical Assistance Administration reimbursement.

4. Make a copy of the Planned Home Birth Outcome Report(s) for your records. Mail a copy of the report to the designated quality assurance/quality improvement (QA/QI) organization (see Important Contacts section for address).

5. Make copies of the reports to maintain a supply or write to MAA's Home Birth Program Manager for additional copies.

Note: Complete the one-page short form even if you transfer care of your client to another provider and are billing for antepartum care only.

Instructions for Completing
Planned Home Birth Outcome Report(s) (cont.)

I. CLIENT IDENTIFICATION

1. Name
- Mother's full name-- last name, first name, and middle initial.

2. Mother's DOB
- Indicate the mother's date of birth with two digits for the month, two digits for the day, and four digits for the year (MMDDYY).

3. Mother's age at delivery
- Indicate the mother's age at the time of delivery.

4. Estimated Date of Delivery
- Indicate the estimated date of delivery using two digits for the month, two digits for the day, and four digits for the year.

5. Mother's race
- Indicate the mother's self-identified race as noted on the newborn's birth certificate.
- Check only one box.
- If other, specify in the space provided.

6. Baby's DOB
- Indicate the infant's date of birth with two digits for the month, two digits for the day, and four digits for the year.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's date of birth.
- Check "not applicable" if the pregnancy ended in spontaneous or therapeutic abortion.

7. Gestational age at delivery
- Indicate the gestational age of the infant at birth by the estimated date of delivery and by newborn exam.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the gestational age.

8. Birthweight
- Write in the infant's weight at birth in grams, or in pounds and ounces.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's birth weight.

9. Infant sex

- Indicate the infant's gender.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's gender.

10. Place of birth

- Check only one box to indicate the place of birth:
  - ✓ Check "home" if the infant was born at home.
  - ✓ Check "birth center" if the infant was born in a birth center.
  - ✓ Check "hospital" if the infant was born in hospital.
  - ✓ Check "unknown" if you complete the form before the birth (if the mother transfers from your care) and you do not know the place of birth.
  - ✓ Check "other" and specify the place of birth if the infant was not born at home or in hospital.

11. Type of delivery

- Check only one box to indicate the type of delivery
  - ✓ Check "Sab" if the pregnancy ended in spontaneous abortion.
  - ✓ Check "Tab" if the pregnancy ended in therapeutic abortion.
  - ✓ Check "NSVD" if the birth was a normal spontaneous vaginal delivery.
  - ✓ Check "Forceps" if the mother was transferred to hospital for a forceps delivery.
  - ✓ Check "Vacuum" if the mother was transferred to hospital for a vacuum extraction.
  - ✓ Check "Cesarean" if the mother was transferred to hospital for cesarean section.
  - ✓ Check "Unknown" if the mother transferred care and you do not know the type of delivery.

II. MATERNITY CARE

12. Gravida

- Indicate the number of times the woman has been pregnant.

13. Para

- Indicate the number of times the woman has had a live birth (>20 weeks gestation).

14. Weeks gestation at first prenatal visit with home birth provider

- Indicate the estimated number of weeks gestation at the time the woman initiated prenatal care with you. (Note: this may not be the same as the number of weeks gestation at the time the woman entered prenatal care.)

15. Prior prenatal care

- Check "yes" or "no" to indicate whether or not the woman had prior prenatal care with another provider prior to initiating care with you. Check "unknown" if you do not know whether or not the woman had prior prenatal care.

16. Total number of visits with home birth provider

- Indicate the number of prenatal visits the woman had while in your care.

17. Reason for Prenatal Transfer of Care **To be filled out for one-paged report only.**

- Check reason for prenatal transfer of care.

III. PERINATAL COMPLICATIONS

Maternal Complications in Past Pregnancies

- For each complication listed, check either "Yes," "No," or "Don't Know" to indicate whether the woman had that complication in her obstetric history.
- If requested, indicate the number of weeks gestation at which the event occurred.
- Explain any "yes" or "don't know" answers in the space provided; attach additional pages as needed.
- If an item is marked with an asterisk (*) indicate whether or not you submitted a bill to MAA for home birth for the current pregnancy.

Maternal Complications This Pregnancy

- For each complication listed, check either "Yes" or "No" to indicate whether the woman had that complication.
- If the woman was admitted or readmitted to a hospital within the first 7 days of birth, indicate the hospital length of stay in days.
- If estimated blood loss was more than 500cc, write in the amount.
- Write in "Other" unlisted complications if experienced by the mother.
- Explain any "Yes" or "Don't Know" answers in the space provided; attach additional pages as needed.
- If an item is marked with an asterisk (*) indicate whether or not you submitted a bill to MAA for home birth for the current pregnancy.

Neonatal Complications

- For each complication listed, check either "Yes," "No," or "Don't Know" to indicate whether the infant had that complication.
- If the newborn was admitted or readmitted to a hospital within the first 7 days of birth, indicate the hospital length of stay in days.
- If the newborn was admitted or readmitted to a NICU (neonatal intensive care unit) within the first 7 days of birth, indicate the hospital length of stay in days.
- Write in "Other" unlisted complications experienced by the infant.
- Explain any "yes" or "don't know" answers in the space provided; attach additional pages as needed.

IV. CONSULTATIONS, REFERRALS AND TRANSFERS

Definitions:

Referral - The process by which the home birth provider directs the client to a physician for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Consultation - The process whereby the home birth provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician (MD or DO) or ARNP on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone.

Complete one row of the table for <u>each</u> time you consulted with, or referred the woman to, another provider for <u>pregnancy-related</u> reasons.

Date -
Indicate the date of the consultation, referral or transfer with two digits for the month, two digits for the day, and four digits for the year.

Timing of Consultation, Referral or Transfer -

- Indicate when the consultation or transfer took place and for which client (mother or newborn) by checking the appropriate box using the following definitions:

  - ✓ ANTEPARTUM (AP) refers to the mother's care prior to the onset of labor.
  - ✓ INTRAPARTUM (IP) refers to the mother's care in the home any time after the onset of labor, up to and including the delivery of the placenta.
  - ✓ POSTPARTUM (PP) refers to the mother's care in the first 7 days postpartum.
  - ✓ NEWBORN (NB) refers to the infant's care in the first 7 days postpartum.

- If AP or IP, indicate the gestational age in weeks. If PP or NB indicate the number of days postpartum.

Type of Provider –
In the space provided, write the number that corresponds to the type of provider who consulted with you, or assumed the woman's care (1=MD; 2=DO; 3=ARNP; 4=Unknown; 5=Other). If '5' (other) please specify the type of provider in the space provided.

Reason for Consultation -
Refer to the attached document "Consultation, Referral and Transfer Code List." Find the section (Antepartum, Intrapartum, Postpartum, or Newborn) that corresponds to the period when the consultation or transfer took place. Choose the number in that section that corresponds to the reason for the consultation or transfer. Write this number in the space provided. If you choose the number for "other," specify the reason for consultation or transfer in the space provided. Attach a separate page to explain as needed.

Management Plan After Consultation -
In the space provided, write the number that corresponds to the outcome of the consultation or transfer.

1= Telephone or electronic consult only;
2 = Referral for examination and/or treatment with return to home birth provider;
3 = Co-management care by home birth provider and consulting provider;
4 = Temporary transfer of care to another provider with return to home birth provider for follow-up;
5 = Permanent transfer of care to another provider.

If '3' or '4', indicate when the co-management or transfer took place in weeks gestation.

Was Transport Emergent?

Was there an emergent transport of the client? Check one box "yes", "no" or "N/A" to indicate whether there was an emergent transport at the time of consultation or transfer. Check "not applicable" if the consultation, referral or transfer did not result in maternal or infant transport.

SHORT REPORT (1 Page)
DSHS PLANNED HOME BIRTH OUTCOME REPORT (Prenatal Care Only)

MAA PROVIDER NUMBER: __ __ __ __ __ __ __ Mom's PIC#: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

I. CLIENT IDENTIFICATION

1. NAME (Last/First/MI): _____ 2. Mother's DOB: __ __/__ __/__ __ __ __
3. Mother's age: _____ 4. Estimated Date of Delivery: __ __/__ __/__ __ __ __
5. Mother's race: ❑ Caucasian ❑ Asian ❑ African American ❑ Native American ❑ Hispanic ❑ Other (specify) _____

II. MATERNITY CARE

12. Gravida _____ 13. Para _____
14. Weeks gestation at first prenatal visit with home birth provider: _____ (weeks)
15. Prior prenatal care ❑ yes ❑ no ❑ unknown 16. Total number of visits with home birth provider _____

III. REASON FOR PRENATAL TRANSFER OF CARE

17. ❑ Moved out of area ❑ Client Chose a New Provider ❑ Transferred to Healthy Options
❑ Other Non-Medical Indication, Specify _____
❑ Medical Indication, Specify _____

IV. CONSULTATIONS AND REFERRALS **Complete one row of table for each *pregnancy-related* consultation or referral prior to transfer**

Date	**Timing of Consultation** (Weeks gestation)	**Provider Type** Code 1 = MD 2 = DO 3= ARNP 4 = Unknown 5 = Other (specify)	**Reason** - see AP Section 'Consultation, Referral Transfer' Code List - If "Other," specify	**Management Plan** Code: 1 = Telephone or electronic consult only 2 = Referral for examination and/or treatment only 3 = Care Co-managed before transfer
__/__/____	_____weeks	Provider Type Code: _____	Consultation Code: _____	Management Plan Code: _____
__/__/____	_____weeks	Provider Type Code: _____	Consultation Code: _____	Management Plan Code: _____
__/__/____	_____weeks	Provider Type Code: _____	Consultation Code: _____	Management Plan Code: _____

V. PERINATAL COMPLICATIONS

Note: E*xplain any yes or don't know answers in the space provided.*

Maternal Complications in Past Pregnancies	**NO**	**YES**	**DON'T KNOW**	
Prior preterm delivery <37 weeks; if yes @ _____ wks. gest.	❑	❑		_____
*Prior Cesarean section	❑	❑		_____
Prior fetal demise (>20 wks. gest)	❑	❑		_____
Other (specify): _____				_____
Maternal Complications This Pregnancy				
Hypertension (chronic or PIH)	❑	❑	❑	_____
Drug/alcohol abuse	❑	❑	❑	_____
Diabetes uncontrolled by diet (gestational or established)	❑	❑	❑	_____
Maternal seizure	❑	❑	❑	_____
Other (specify): _____				

I agree that the above is true to the best of my knowledge.

Signed _____ Print Name _____ Date ___ ___ / ___ ___ / ___ ___ ___ ___

Submit this form to:

OMPRO - ATTN: Home Birth Program Manager
2020 SW 4th Avenue, Ste. 520
Portland, OR 97201-4960

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DSHS PLANNED HOME BIRTH OUTCOME REPORT

MAA PROVIDER NUMBER: __ __ __ __ __ __ __ Mom's PIC#: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

I. CLIENT IDENTIFICATION

1. NAME (Last/First/MI): _____ 2. Mother's DOB: __ __/__ __/__ __ __ __
3. Mother's age at delivery: _____ 4. Estimated Date of Delivery: __ __/__ __/__ __ __ __
5. Mother's race: ❑ Caucasian ❑ Asian ❑ African American ❑ Native American ❑ Hispanic ❑ Other (specify) _____
6. Baby's DOB: __ __/__ __/__ __ __ __ ❑ Unknown ❑ Not Applicable
7. Gestational age at delivery: by EDD ____ (weeks) by newborn exam ____ (weeks) ❑ Unknown
8. Birthweight _____ (grams) or _____ (lbs./os.) ❑ Unknown
9. Infant sex: ❑ Female ❑ Male ❑ Unknown
10. Place of birth: ❑ Home ❑ Birth Center ❑ Hospital ❑ Unknown ❑ Other (specify _____
11. Type of delivery: ❑ SAB ❑ TAB ❑ NSVD ❑ Forceps ❑ Vacuum ❑ Cesarean section ❑ Unknown

II. MATERNITY CARE

12. Gravida _____ 13. Para _____
14. Weeks gestation at first prenatal visit with home birth provider: _____ (weeks)
15. Prior prenatal care ❑ yes ❑ no ❑ unknown 16. Total number of visits with home birth provider _____

III. PERINATAL COMPLICATIONS

Note: E*xplain any yes or don't know answers in the space provided. For items marked (*), indicate if MAA was billed for home birth for current pregnancy.*

Maternal Complications in Past Pregnancies	**NO**	**YES**	**DON'T KNOW**	
Prior preterm delivery <37 weeks; if yes @ _____ wks. gest.	❑	❑		
*Prior Cesarean section	❑	❑		
Prior fetal demise (>20 wks. gest)	❑	❑		
Other (specify): _____				
Maternal Complications This Pregnancy				
Hypertension (chronic or PIH)	❑	❑	❑	
Drug/alcohol abuse	❑	❑	❑	
Diabetes uncontrolled by diet (gestational or established)	❑	❑	❑	
*Breech birth	❑	❑	❑	
*Multiple birth	❑	❑	❑	
Signs & symptoms of uterine infection or maternal sepsis	❑	❑	❑	
Hospital or ER admission/ readmission within 7 days post-birth if yes, specify length of stay in days_____	❑	❑	❑	
3rd or 4th degree laceration (Specify: 3rd ❑ or 4th ❑)	❑	❑	❑	
Cord prolapse	❑	❑	❑	
Uterine prolapse or inversion	❑	❑	❑	
Uterine rupture	❑	❑	❑	
Sustained maternal vital sign instability and/or shock	❑	❑	❑	
Maternal seizure	❑	❑	❑	
Est. blood loss >500 cc If yes, _____ cc (amt.)	❑	❑	❑	
Maternal death	❑	❑	❑	
Other (specify): _____				
Neonatal Complications				
Thick meconium	❑	❑	❑	
5 minute Apgar score ≤ 6	❑	❑	❑	
Major apparent congenital anomalies	❑	❑	❑	
Hospital or ER admission/ readmission within 7 days post-birth if yes, specify length of stay in days_____	❑	❑	❑	
NICU admission/ readmission within 7 days post-birth if yes, specify length of stay in days_____	❑	❑	❑	
Birth injury	❑	❑	❑	
Assisted ventilation at birth (ppv) > 1 minute	❑	❑	❑	
Neonatal seizure	❑	❑	❑	
Sepsis	❑	❑	❑	
Intrapartum stillbirth	❑	❑	❑	
Fetal demise (>20 wks. gest.)	❑	❑	❑	
Neonatal death	❑	❑	❑	
Other (specify): _____				

CONSULTATION, REFERRAL AND TRANSFER CODE LIST

ANTEPARTUM
(refers to the mother's care prior to the onset of labor)

AP1. Breech at 37 weeks;
AP2. Polyhydramnios/Oligohydramnios;
AP3. Significant vaginal bleeding;
AP4. Persistent nausea and vomiting causing a weight loss of >15 lbs.;
AP5. Post-dates pregnancy (>42 completed weeks);
AP6. Fetal demise after 12 completed weeks gestation;
AP7. Significant size/dates discrepancies;
AP8. Abnormal fetal NST;
AP9. Abnormal ultrasound findings;
AP10. Acute pyelonephritis;
AP11. Infections, whose treatment is beyond the scope of the home birth provider;
AP12. Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality;
AP13. No prenatal care prior to the third trimester;
AP14. Evidence of pregnancy-induced hypertension;
AP15. Hydatidiform mole (molar pregnancy);
AP 16. Gestational diabetes not controlled by diet;
AP17. Severe anemia unresponsive to treatment;
AP18. Known fetal anomalies or conditions affected by site of birth;
AP19. Noncompliance with the plan of care (e.g., frequent missed visits);
AP20. Documented placental abnormalities, significant abruption past the 1st trimester or any evidence of previa in the 3rd trimester.
AP21. ROM before the completion of 37 weeks gestation;
AP22. Positive HIV antibody test;
AP23. Documented IUGR;
AP24. Primary genital herpes past the 1st trimester;
AP25. Other significant deviations from normal, as assessed by the home birth provider (specify the reason in the space provided).

INTRAPARTUM
(refers to the mother's care in the home any time after the onset of labor, up to and including the delivery of the placenta)

IP1. Prolonged rupture of membranes (>24 hours and not in active labor);
IP2. Labor before the completion of 37 weeks gestation, with known dates;
IP3. Abnormal presentation or lie at time of delivery, including breech;
IP4. Maternal desire for pain medication, consultation or referral;
IP5. Persistent nonreassuring fetal heart rate;
IP6. Active genital herpes at the onset of labor;
IP7. Thick meconium-stained fluid with delivery not imminent;
IP8. Prolapse of the umbilical cord;
IP9. Signs and symptoms of uterine infection or maternal sepsis;
IP10. Maternal seizure;
IP11. Abnormal bleeding;
IP12. Hypertension with or without additional signs or symptoms of pre-eclampsia;
IP13. Prolonged failure or progress in active labor;
IP14. Other significant deviations from normal as assessed by the home birth provider or development of any of the conditions listed previously (specify the reason in the space provided).

POSTPARTUM
(refers to the mother's care in the home in the 7 days after birth)

PP1. Significant maternal confusion or disorientation;
PP2. Anaphylaxis or shock;
PP3. Undelivered adhered or retailed placenta with or without bleeding;
PP4. Significant hemorrhage not responsive to treatment;
PP5. Maternal seizure;
PP6. Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree);
PP7. Sustained maternal vital sign instability;
PP8. Development of s/sx of infection or sepsis;
PP9. Acute respiratory distress;
PP10. Uterine prolapse or inversion;
PP11. Other significant deviations from normal as assessed by the home birth provider or development of any of the conditions listed previously (specify the reason in the space provided).

NEWBORN
(refers to the infant's care in the home during the first 7 days after birth)

NB1. Apgar score less than or equal to 6 at five minutes of age;
NB2. Birthweight <2500 grams;
NB3. Abnormal jaundice;
NB4. Birthweight <2000;
NB5. Persistent respiratory distress;
NB6. Persistent cardiac abnormalities or irregularities;
NB7. Persistent central cyanosis or pallor;
NB8. Prolonged temperature instability when intervention has failed; or neonatal sepsis;
NB9. Prolonged glycemic instability;
NB10. Neonatal seizure;
NB11. Clinical evidence of prematurity (gestational age <35 weeks);
NB12. Loss of >10% of birthweight/failure to thrive;
NB13. Birth injury requiring medical attention;
NB14. Major apparent congenital anomalies;
NB15. Other significant deviations from normal as assessed by the home birth provider (specify the reason in the space provided).

IV. CONSULTATIONS, REFERRALS AND TRANSFERS

Complete one row of this table for each pregnancy-related consultation, referral or transfer.

Date	**Timing of Consultation, Referral or Transfer** AP - Ante Partum IP - Intra Partum PP - Post Partum (mother) NB – Newborn Check one box and fill in the corresponding blank.	**Provider Type** Code 1 = MD 2 = DO 3= ARNP 4 = Unknown 5 = Other (specify)	**Reason for Consultation, Referral or Transfer** - see 'Consultation, Referral and Transfer' Code List - If "Other," specify	**Management Plan** Code: 1 = Telephone or electronic consult only 2 = Referral for examination and/or treatment; return to home birth provider 3 = Co-management care by home birth provider and consulting provider 4 = Temporary transfer of care to another provider with return to home birth provider for follow-up 5 = Permanent transfer of care to another provider	Was Transport Emergent? (Check one box; N/A- not applicable)
__/__/_____	❑ AP @ _____weeks gestation ❑ IP @ _____weeks gestation ❑ PP @ _____days ❑ NB @ _____days	Provider Type Code: ______	Consultation Code: ______	Management Plan Code: _____ If 3 or 4, return to home birth provider @ _____ weeks	❑ No ❑ Yes ❑ N/A
__/__/_____	❑ AP @ _____weeks gestation ❑ IP @ _____weeks gestation ❑ PP @ _____days ❑ NB @ _____days	Provider Type Code: ______	Consultation Code: ______	Management Plan Code: _____ If 3 or 4, return to home birth provider @ _____ weeks	❑ No ❑ Yes ❑ N/A
__/__/_____	❑ AP @ _____weeks gestation ❑ IP @ _____weeks gestation ❑ PP @ _____days ❑ NB @ _____days	Provider Type Code: ______	Consultation Code: ______	Management Plan Code: _____ If 3 or 4, return to home birth provider @ _____ weeks	❑ No ❑ Yes ❑ N/A
__/__/_____	❑ AP @ _____weeks gestation ❑ IP @ _____weeks gestation ❑ PP @ _____days ❑ NB @ _____days	Provider Type Code: ______	Consultation Code: ______	Management Plan Code: _____ If 3 or 4, return to home birth provider @ _____ weeks	❑ No ❑ Yes ❑ N/A
__/__/_____	❑ AP @ _____weeks gestation ❑ IP @ _____weeks gestation ❑ PP @ _____days ❑ NB @ _____days	Provider Type Code: ______	Consultation Code: ______	Management Plan Code: _____ If 3 or 4, return to home birth provider @ _____ weeks	❑ No ❑ Yes ❑ N/A

I agree that the above is true to the best of my knowledge.

Signed ____ Print Name _____________________________ Date ___ ___ / ___ ___ / ___ ___ ___ ___

Submit this form to:

OMPRO
ATTN: Home Birth Program Manager
2020 SW 4th Avenue, Ste. 520
Portland, OR 97201-4960

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Authorization

Expedited Prior Authorization (EPA)

What is the EPA process?

MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

When do I need to create an EPA number?

Drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule can be administered by licensed midwives when ordered by a physician. For licensed midwives to be reimbursed by MAA for the administration of these drugs, the licensed midwife must meet the EPA criteria listed below.

How do I create an EPA number?

Once the EPA criteria is met, the licensed midwife must create a 9-digit EPA number.
The first six digits of the EPA number must be 870000**.**
The last 3 digits must be the EPA criteria listed below (**690**).

☞ **Note:** Licensed midwives are reminded that this EPA number is ONLY for the procedure codes listed in the fee schedule as "Not billable by a Licensed Midwife."

EPA Criteria for Drugs "Not Billable by Licensed Midwives"

Procedure Codes: 90371, J2540, S0077, J0290, J1364

690 Licensed midwife has met all of the following:

- Obtained physician or standing order for the administration of the drug(s) listed as "not billable by a licensed midwife;"
- The physician or standing order are located in the client's file; and
- The licensed midwife will provide a copy of the physician or standing order to MAA upon request.

🗁**BILLING**: Enter the EPA number (**870000690**) in field 23 (Prior Authorization) on the HCFA-1500 claim form.
DO NOT HANDWRITE THE EPA NUMBER ONTO THE CLAIM. (See "Guidelines for completing the HCFA-1500 claim form.)

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Billing

Billing – Specific to Planned Home Births

Effective for dates of service on and after July 1, 2004, MAA will no longer reimburse providers for prenatal assessments. If a client is seen for reasons other than routine antepartum care, eligible providers (ARNPs) must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

Exception: Providers must bill E&M codes for antepartum care if only 1-3 antepartum visits are done, as discussed later in these billing instructions.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

Note: **Do not** bill MAA for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you will not be able to bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care prior to the transfer bills for the services that he/she performed. Therefore, if you bill the global OB package, you would be billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Only those services you actually provide to the client may be billed to MAA.

If your client changes insurance during her pregnancy…

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in a MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The managed care plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

☞ **Note:** **Do not** bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill MAA using the vaginal delivery only code (CPT code 59409).

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA using the vaginal delivery, including postpartum care code (CPT code 59410).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Increased Monitoring

When providing **increased monitoring** for the conditions listed on page E.1 – E.2 in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

If the client has one of the conditions listed on page E.1 –E.2, the provider is not automatically entitled to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.

Note: Licensed midwives are limited to billing for certain medical conditions (see page E.1 – E.2) that require additional monitoring under this program.

For example:

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits, and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and attended the client during labor, but transferred the client to another provider (outside of your group practice) for delivery, you must unbundle the global OB package and bill separately for antepartum care and the time spent managing the client's labor. The client must be in active labor when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for the time spent attending the client's labor using the appropriate CPT E&M **codes ~~99211-99215 with modifier TH (for labor attended in the office) or~~ 99347-99350** (for labor attended at the client's home). In addition, MAA will reimburse providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH**. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

Note: The E&M code and the prolonged services code(s) **must** be billed on the same claim form.

Department of Health (DOH) Newborn Screening Tests

A midwife or physician may bill MAA for a newborn screening test for metabolic disorders (HCPCS code S3620) after paying DOH for the cost of the test. The newborn screening panel includes screens for:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD;
- Homocystinuria; and,
- Galactosemisa.

Reimbursement includes two tests for two different dates of service, and is **allowed once per newborn.** Do not bill MAA for the newborn screening test if the baby is born in the hospital.

Immunizations

Immunization administration CPT codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, please refer to MAA's Physician-Related Services Billing Instructions or EPSDT Billing Instructions.

You may view these billings instructions online at **http://maa.dshs.wa.gov** (click on the "Provider Publications/Fee Schedules" link).

Home Birth Kit

When disposable items are used, bill MAA for a home birth kit using HCPCS code S8415. Reimbursement is **limited to one per client, per pregnancy.**

Medications

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in MAA's fee schedule are not billable by Licensed Midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as "not billable by a licensed midwife" must be obtained at a pharmacy with a physician order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section F - Authorization** for further information on billing**.**

☞ **Note**: Drugs must be billed using the procedure codes listed in the fee schedule and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review.

Newborn Assessment

To bill for a newborn assessment completed at the time of the home birth, providers must bill using CPT code 99432. Reimbursement is **limited to one per newborn.** Do not bill CPT code 99432 if the baby is born in a hospital.

Home Births Outcome Reports

The purpose of the Planned Home Births Outcome Report(s) is to provide the following data to MAA: prenatal history, transfer, and perinatal complications. The data is used to maintain a quality and outcomes monitoring process by analyzing data to evaluate the clinical practice of MAA's planned home birth providers.

You must submit a copy of the **Home Births Outcome Report(s)** and your claim form to the appropriate addresses as listed in the *Important Contacts* section (page iii). The one page short form can be completed if you are billing for antepartum care only.

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Billing – General to all Medical Assistance Programs

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - ➢ The date the provider furnishes the service to the eligible client;
    - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
    - ➢ The date a court orders MAA to cover the services; or
    - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - ➢ DSHS certification of a client for a retroactive[2] period; or
    - ➢ The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the MAA seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the service(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not field 17a when you bill MAA, the claim will be denied.

What documentation must be kept in the client's record?

[Refer to WAC 388-502-0020]

Specific to Planned Home Births

Antepartum Care

- Initial general (Gen) history, physical examination, and prenatal lab tests.
- Gynecological (Gyn) history, including obstetrical history, physical examination, and standard lab tests. Ultrasound, if indicated.
- Subsequent Gen/Gyn history, physical and lab tests.
- Client's weight, blood pressure, fetal heart tones, fundal height, and fetal position at appropriate gestational age.
- Consultation, referrals, and reason for transferring care, if necessary.
- Health education and counseling.
- Consultation or actual evaluation by the consulting physician for any high-risk condition.
- Risk screening evaluation.

Intrapartum/Postpartum Care

- Labor, delivery, and postpartum periods.
- Maternal, fetal, and newborn well being, including monitoring of vital signs, procedures, and lab tests.
- Any consultation referrals and reason for transferring care, if necessary.
- Initial pediatric care for newborn, including the name of the pediatric care provider, if known.
- Postpartum follow-up, including family planning.

Informed Consent

- Copy of informed consent, including all of the following:

  - ✓ Scope of maternal and infant care;
  - ✓ Description of services provided;
  - ✓ Limitations of technology and equipment in the home birth setting;
  - ✓ Authority to treat;
  - ✓ Plan for physician consultation or referral;
  - ✓ Emergency plan;
  - ✓ Informed assumption of risks; and
  - ✓ Client responsibilities.

General to all providers

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

Correct Coding Initiative (CCI)

As of January 2002 the Medical Assistance Administration (MAA) began evaluating and implementing Medicare's National Correct Coding Initiative (CCI). CCI changes could affect reimbursements to providers for CPT™ and HCPCS procedure codes.

CCI was created by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding by physicians and providers and to ensure that appropriate payments are made for provider services. CCI coding policies are based on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- Analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

CCI coding policies do not supercede MAA's current Washington Administrative Code (WAC) regarding coverage and reimbursement policies or MAA Billing Instructions and Numbered Memoranda.

Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Planned Home Birth services:

Routine Antepartum Care			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
☞ **Note:** CPT codes 59425, 59426, or E&M codes 99211-99215 TH with normal pregnancy diagnoses V22.0-V22.2 **may not** be billed in combination during the entire pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**			
59425		Antepartum care, 4-6 visits. **Limited to 1 unit per client, per pregnancy, per provider.**	$442.58
59426		Antepartum care, 7 or more visits. **Limited to 1 unit per client, per pregnancy, per provider.**	776.62
99211	TH	Office visits, antepartum care 1-3 visits, w/obstetrical service modifier. **99211 – 99215 limited to 3 units total, per pregnancy, per provider.** Must use modifier TH when billing.	14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

Corrected online only since original posting

Additional Monitoring

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞ **Note:** Midwives who provide increase monitoring for the diagnoses listed on pages E.1 and E.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with the modifier TH.			
99211	TH	Office/outpatient visit, est	$14.25
99212	TH	Office/outpatient visit, est	25.25
99213	TH	Office/outpatient visit, est	35.25
99214	TH	Office/outpatient visit, est	55.00
99215	TH	Office/outpatient visit, est	79.75

Delivery (Intrapartum)

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59400		Obstetrical care [prenatal, delivery, and postpartum care]	$1,899.78
59409		Obstetrical care [delivery only]	943.89
59410		Obstetrical care [delivery and postpartum only]	1,056.37

Postpartum

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
59430		Care after delivery [postpartum only]	$167.17

Labor Management

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/04
☞		**Note:** Bill only when the client labors at ~~the birthing center or at~~ home and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The following diagnoses must be used 640–674.9; V22.0–V22.2; and V23–V23.9.	
☞		**Note:** Labor management may not be billed by the delivering physician. Prolonged services must be billed on the same claim form as E&M codes along with modifier TH and one of the diagnoses listed above must be on each detail line of the claim form.	
~~99211~~	~~TH~~	~~Office/outpatient visit, est (Use when client labors at birthing center)~~	~~$14.25~~
~~99212~~	~~TH~~	~~Office/outpatient visit, est~~	~~25.25~~
~~99213~~	~~TH~~	~~Office/outpatient visit, est~~	~~35.25~~
~~99214~~	~~TH~~	~~Office/outpatient visit, est~~	~~55.00~~
~~99215~~	~~TH~~	~~Office/outpatient visit, est~~	~~79.75~~
99347	TH	Home visit, est patient	26.98
99348	TH	Home visit, est patient	45.79
99349	TH	Home visit, est patient	70.96
99350	TH	Home visit, est patient	103.15
+ 99354	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	58.72
+ 99355	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	58.26

(+) = Add-on code

Corrected online only since original posting

Other			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
59025		Fetal non-stress test	$48.91
59025	TC	Fetal non-stress test	11.56
59025	26	Fetal non-stress test	37.35
36415		Drawing blood	2.45
84703		Chorionic gonadotropin assay	8.36
85013		Hematocrit	2.64
85014		Hematocrit	2.64
A4266		Diaphragm	45.0
A4261		Cervical cap for contraceptive use	47.0
57170		Fitting of diaphragm/cap	56.90
90782		Injection, sc/im	11.34
90371		Hep b ig, im **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	116.28 per each 1 ml
J2790		Rh immune globulin	89.76
J2540		Injection, penicillin G potassium, up to 600,000 units. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	0.26
S0077		Injection, clindamycin phosphate, 300 mg. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	Acquisition Cost
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	1.48

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	$3.14
J7050		Infusion, normal saline solution, 250cc	2.22
S5011		5% dextrose in lactated ringer's, 1000 ml.	Acquisition Cost
J7120		Ringers lactate infusion, up to 1000cc	11.13
J2210		Injection methylergonovine maleate, up to 0.2mg	3.67
J3475		Injection, magnesium sulfate, per 500 mg	0.20
J2590		Injection, oxytocin	1.15
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	2.10
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	1.98
90708		Measles-rubella vaccine, sc	21.81
90471		Immunization admin	5.00
90472		Immunization admin, each add **[List separately in addition to code for primary procedure.]**	3.00
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel. **[Department of Health newborn screening tests for metabolic disorders. Includes 2 tests on separate dates; one per newborn.]**	60.90

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/04**
99401		Preventive counseling, indiv [approximately 15 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only**]	$25.39
99402		Preventive counseling, indiv [approximately 30 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only**]	42.62
99432		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s). **Limited to one per newborn. Do not bill MAA if baby is born in a hospital.**	72.45
99440		Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	90.45
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	113.12
S8415		Supplies for home delivery of infant. **Limited to 1 per client, per pregnancy.**	45.00

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1A. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's DSHS Medical ID card. This number consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- Tom O'Malley's PIC should look like this: TC020652O'MALA (**Note:** Always use the exact PIC as it appears on the client's Medical ID card regardless of whether it follows the above examples.)

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, and private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. When applicable. When billing for baby using the mother's PIC**, enter "B".**

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 05, 2003 = 070503).

24B. **Place of Service**: Required.

Prior to dates of service October 1, 2003, use the following Place of Service codes:

3 Office
4 Home

On and after October 1, 2003, use the following Place of Service codes:

11 Office
12 Home

24C. **Type of Service**: Required prior to October 1, 2003, dates of service. Enter a 3 for all services billed.

For claims with dates of service on and after October 1, 2003, this field IS NOT A REQUIRED FIELD.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume or use related item #s. Example: 1, 2, 3, etc from field 21.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of units for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**

B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Billing Home Birth

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MK070174SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY K

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 74 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1800 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. 650
3. V27.0
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	03	01	01	03	3	3	T1001	TH	1	5000	1				
2	07	01	03	07	01	03	4	3	59400		2, 3	182680	1				
3	07	01	03	07	01	03	4	3	S8415		2	4500	1				
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 192180

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 192180

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

TONI ANDERSON, LM 123 8TH AVENUE
ANYTOWN WA 98000

PIN# 7090000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

BILLING BABY'S CARE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): CC122175JONESA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JONES SUSAN B

3. PATIENT'S BIRTH DATE MM DD YY: 03 02 80 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 SPRING STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 98500 TELEPHONE (Include Area Code): (360) 325-1000

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: B (INDICATES BABY UNDER MOTHER'S PIC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V30.2
2. 650.
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	07	04	03	07	04	03	4	3	99432			5000	1				
2	07	04	03	07	04	03	4	3	S3620			6440	1				
3	07	04	03	07	04	03	4	3	36415			245	1				
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 11685

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 11685

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
MARY SMITH 100 AVENUE W
SEATTLE WA 98100 (206) 525-0000

PIN# 7005000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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